Technical Report No. 19

The Contribution of Mutual Health Organizations to Financing, Delivery, and Access in Health Care in West and Central Africa: Summaries of Synthesis and Case Studies in Six Countries

May 1998

Prepared by:

Chris Bukari Atim, Ph.D.
Consultant, Abt Associates Inc.

François Pathé Diop, Ph.D.
Consultant, Abt Associates Inc.

Jean Etté, Ph.D.
Consultant, Abt Associates Inc.

Dominique Evrard
Alliance Nationale de Mutualités Chrétiennes de Belgique

Philippe Marcadent
Stratégies et Techniques de lutte contre l'Exclusion social et la Pauvreté
BIT/STEP

Nathalie Massiot
Appui associatif et coopératif aux initiatives de developpement á la base
BIT/ACOPAM

Partnerships for Health Reform
PHR

Abt Associates Inc. # 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 # Tel: 301/913-0500 # Fax: 301/652-3916

In collaboration with:

Development Associates, Inc. # Harvard School of Public Health #
Howard University International Affairs Center # University Research Corporation

Partnerships
for Health
Reform

PHR

Mission

The Partnerships for Health Reform Project (PHR) seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *policy formulation and implementation*
- *health economics and financing*
- *organization and management of health systems*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and informs and guides the exchange of knowledge on critical health reform issues.

May 1998

Recommended Citation

Atim, Chris Bukari, François Pathé Diop, Jean Etté, Dominique Evrard, Philippe Marcadent and Nathalie Massiot. May 1998. *The Contribution of Mutual Health Organizations to Financing, Delivery, and Access in Health Care in West and Central Africa: Summaries of Synthesis and Case Studies in Six Countries.* Technical Report No. 19. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

For additional copies of this report, contact the PHR Resource Center at PHR-InfoCenter@abtassoc.com or visit our website at www.phrproject.com.

Contract No.:	HRN-5974-C-00-5024-00
Project No.:	936-5974.13
Submitted to:	USAID/REDSO/WCA
and:	Robert Emrey, COTR Health Policy and Sector Reform Division Office of Health and Nutrition Center for Population, Health and Nutrition Bureau for Global Programs, Field Support and Research United States Agency for International Development

Foreword

This volume is the product of a collaborative research initiative carried out between June 1997 and May 1998 on mutual health organizations (MHOs) in West and Central Africa, led by USAID-PHR, ILO (ACOPAM and STEP Programs), WSM and ANMC, with participation from the French Cooperation, UNICEF, ORSTOM and GTZ. The purpose of the research is to evaluate the experience and potential of MHOs to improve health care financing, access and service delivery and to provide recommendations to MHOs, health care providers, governments, and donors. A draft of the synthesis paper, an inventory of 50 MHOs in six countries and case studies of Côte d'Ivoire, Sénégal, Mali, Nigeria, Ghana, and Benin, studying a total of 22 MHOs, have been completed.

This volume presents the executive summary of the synthesis paper, as well as those from the six case studies from West Africa. Also included are a table summarizing the main features of case study MHOs, a list of MHOs investigated by country (from both the inventory and the case studies), and a list of acronyms as annexes. This set of summaries is intended to provide an overview of the lessons learned from this research. This will be followed by publication of a three volume set: Volume I will include a full version of the synthesis paper, together with the methodological guidelines that served as the framework for the case studies; Volume II will contain the inventory of MHOs; and Volume III will present the complete case studies.

Table of Contents

Acronyms

ACOPAM	Appui associatif et coopératif aux initiatives de dévoppement à la base
ANMC	Alliance Nationale des Mutualités Chrétiennes de Belgique
ASACO	Associations de santé communautaires (Mali)
BASICS	Basic Support for Institutionalizing Child Survival Project (USAID)
BIT	Bureau International du Travail
CARD	Le cercle de Amis de la Rue Dimbokro (Cote d'Ivoire)
CIDR	Centre International de Développement et de Recherche (French NGO)
CPH	Community Partners for Health (BASICS-Nigeria)
CSC	Centres de santé communautaires (Mali)
ESA	East and Southern Africa
FAC	Agence de Coopération Française
FCFA	Franc Communautaire financière africaine
FFS	Fee for Service Payment Method
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ) (German International development assistance program)
ILO	International Labor Organization (English for BIT)
IPM	Institution de Prévoyance Maladie (Senegal)
MC36	l'Amicale des Mamans du Canal (Cote d'Ivoire)
MHO	Mutual Health Organization
MUTEC	la Mutelle des Travailleurs de l'Education Nationale et de la culture (Mali)
NGO	Nongovernment Organization
ORSTOM	Office Recherche Scientifique et Technique Outre Mer
PHC	Primary Health Care
PHR	Partnerships for Health Reform Project
REDSO	Regional Economic Development Support Office (USAID)
STEP	Strategies and Tools against Social Exclusion and Poverty (ILO program)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax

WCA West and Central Africa

Synthesis

Mutuelles, or mutual health organizations (MHOs), are community and employment-based groupings which have grown progressively in West and Central Africa in recent years. With this growth has come interest in mutuelles from governments, NGOs and international organizations, particularly those interested in new and innovative approaches to the difficult issues of health care financing in the sub-region. This interest led a group of international organizations to join together in early 1997, and work from mid-1997 through mid-1998 for the purpose of analyzing the actual and potential contribution of MHOs to the financing, delivery and access to health care in West and Central Africa. Members of the group intended that this analysis would inform their priority setting and assistance strategies, as well as those of others, including the MHOs themselves.

The consultative group has been led by USAID-PHR, the ILO (and its ACOPAM and STEP Programs), WSM and ANMC, with participation from the French Cooperation, UNICEF, ORSTOM and GTZ. The study covered nine WCA countries, compiling data from an inventory of 50 MHOs in 6 countries and more in-depth case studies of 22 selected MHOs in 6 countries. The group based selection and analysis of the case study MHOs on a Methodological Guide developed by a member of the team. Certainly one can characterize the study itself as a successful example of how international organizations can effectively collaborate, sharing personnel and information, and co-financing activities of common interest.

The study represents an important step forward in documentation and understanding of the MHO experience in the WCA subregion. Previous studies have been smaller, more country specific, and have not contained this level of integration and comparison of experience, particularly with the inclusion of the anglophone experience from Nigeria and Ghana. The study systematically examines the contributions, actual and potential, of WCA MHOs to resource mobilization, efficiency, equity, quality improvement, health care access, sustainability and democratic governance of the health sector.

The study also has some limitations. For example, the size and diversity of the consultative group, while definitely a strength, resulted in some variation in interpretations of definitions by field researchers, which affected the number and selection of MHOs -- e.g., IPMs in Senegal were thus not counted in the inventory. In addition, the selection of case study MHOs was based on a certain level of availability of information, which may introduce some bias. A number of areas which would benefit from further examination and observation of trends over time are cited within and at the end of this paper.

The main purpose here is to present information which could be of use to all the key actors in the development of the MHOs: the members and leaders of those organizations themselves, health care providers, policy makers and especially WCA Ministries of Health, development partners (external cooperation agencies and technical support institutions), other MHO promoters such as trade unions, mutualist organizations and associations outside the health sector, and so on. Each of these will find concrete information in the report that could be beneficial in the work that they do with, for, or in the field of, mutual health organizations in West and Central Africa.

On the basis of the findings of this study, it is possible to speak confidently about the emergence of a dynamic of mutual health schemes in West Africa, and to a lesser extent (because only one Central African country was investigated) in Central Africa. These schemes are generally on a small to medium scale in terms of membership. Most are also very young: about two-thirds of the 50 MHOs in the inventory survey were less than three years old.

At present, MHO activities affect only a small fraction of the populations of the countries involved. However, this study shows that they have a great potential to embrace more people as well as to contribute more to the health care sectors of their communities and countries. Even now, they make a significant contribution to health care access and extending social protection to disadvantaged sections of the population by mainly targeting people in the informal and rural sectors. This also represents a contribution to equity in health care in the areas where they are active. Another area in which the MHOs make a new - and in this case, original - contribution is that of democratic governance in the health sector. MHOs are able to claim popular legitimacy in representing their communities or members before the health authorities in order to articulate the views of the consumers of health care. This gives them some weight in influencing the priorities, resource allocation decisions, and responsiveness of the health authorities to the concerns of the public on such issues as waiting times, staff behavior, quality of services, etc. This is a genuinely new contribution which reflects the role and origins of the MHOs as part of the growing and confident civic society that began to develop in Africa in the 1990s.

Though the contribution of MHOs to resource mobilization is currently limited, the study shows that the potential is large given that the current contribution is constrained by factors such as low penetration of the target populations (probably related to design issues which this study indicates can be remedied), low dues collection rates, inadequate marketing, lack of synchronization of dues collection with income earning periods, and other factors.

The study found that MHOs can potentially improve their efficiency significantly through a number of design features, most of which are already well-known, and some of which are implemented by some WCA MHOs. These features that are favorable to scheme success include waiting periods for new members, social control to avoid abuses, co-payments or ceilings on the amounts of cover, some level of obligatory membership - at family, associational or target group level. This latter feature avoids having scheme membership disproportionately composed of high risk persons, by ensuring that membership is extended beyond just those who wish to join voluntarily.

In the area of health care quality improvement, the study found that most MHOs are not well-equipped to realize the potential that they possess in this area. This is so, in part because of their relative youth and lack of experience, partly because of lack of managerial skills and insufficient knowledge of alternative and also due to low levels of negotiating power vis-à-vis the health care providers.

Because of the young age of most of the schemes, it is not possible to make an assessment of their long-term sustainability on the basis of experience to date. However, examining some of the design and institutional features, their administrative and managerial capacities, and the limited data available on their financial performance - including dues collection rates - it is possible to say that there is room for improvement.

These latter issues are, appropriately, among the main issues in the recommendations: how to add value to the experience of these organizations by reinforcing existing capacities, building

new ones and helping to create an enabling environment for the full potential of MHO to be realized. There are many recommendations contained in the synthesis for the MHOs themselves as well as for all the key actors involved in the promotion, development and support of such organizations. The major recommendations have to do with reinforcing the institutional, managerial and administrative capacities of the MHOs.

The primary catalysts and agents of progress will have to be the MHOs themselves. It is their motivation, desire to improve their organizations, and capacities to absorb new knowledge and skills that will drive the success of any support which development partners may be able to provide.

No study can deal exhaustively with all the aspects of a phenomenon as complex and diverse as MHOs and this study does not claim to have done so. In particular, the study did not investigate the social movement dimension or aspiration of the MHOs which is potentially, at least, one of their major and vital contributions to social and civic life. MHOs may serve not only as a means to gain access to health care, but they frequently also may provide important human elements such as comfort, solidarity and emotional support to patients and other members.

It is possible to speculate, from the examples of medical aid societies in Zimbabwe and South Africa (studied separately), on how MHOs could grow in the future and “scale up” to large organizations and even eventually how they might participate in or coordinate with compulsory social health insurance schemes. These aspects, interesting as they are, are not systematically investigated or dealt with here. They could be fruitful areas for extending and building on the work synthesized in this report.

1. Benin

The case studies on mutual health organizations (MHOs), the results of which are presented in this report, are a component of the research done on MHOs in West and Central Africa. This research on MHOs is part of the plan of regional activities of the Regional USAID Office in Abidjan (REDSO/West) in the area of health services financing and management. Support for MHOs has been identified as a priority area of intervention by the representatives from the Ministries of Health in the countries of the subregion who have participated in the successive regional meetings on health services financing and management over the last three years. Although MHOs are in an emerging phase, promotion of mutual organizations is consistent with the policy agenda for health financing and the strengthening of partnerships among the public, private-corporate and community sectors in many of the subregion's countries. The general objective of the research on MHOs is to evaluate their current and potential contribution to health care financing, delivery and access in Africa, particularly with reference to the countries of West and Central Africa.

In September 1997, there were nine MHOs operating in Benin, two other mutual organizations that were encountering operational difficulties, and various experiments in alternative health financing mechanisms designed to spread health risk. These organizations are operating in very different contexts within the country: from rural cotton-producing areas in the south Borgou, to the transition area of central Zou, to the quasi-urban areas of Porto Novo and Cotonou.

This report encompasses the case studies conducted on four of these MHOs. The case studies were carried out during October 1997. Based on the Methodological Guide developed to support case studies in six West African countries, data were collected at the two Communal Unions of Mutualist Organizations in Sirarou and Sanson in the rural areas of south Borgou in northern Benin, the Ilera MHO in Porto-Novo in southeast Benin, and the Alafia de Gbaffo MHO in the rural areas of Zou in the central department of Benin. The data were collected by office staff in mutual organizations, health care provider institutions and aid agencies. Additional data were compiled on the country's economy, population and health situation in order to situate these MHOs in a country context.

The experiences of MHOs in Benin are still too recent and the beneficiary population too weak for their effects on the health system to be clearly discerned. However, local experiences suggest that MHOs could contribute to improving the quality of care and efficiency, financial access, equity and management in the health system.

The fact that the sick wait so long before going to health care facilities is a major problem in the efficient delivery of health care. Those who are sick visit health care facilities only when their condition is extremely serious. A change in behavior that providers have begun to notice is that members of mutual organizations seek health care services sooner than non-members, which could contribute to improving the efficiency of care. Regular visits to health care facilities for childbirth among beneficiary women seem to be positively related to the establishment of MHOs. However, as noted by service providers, the percentage of MHO members among the clients of the health care facilities is still too low to have a significant effect on the facilities' financial

resources, and thus, on improvements in service quality. In other words, MHOs could contribute to a more efficient consumption of health services among covered populations, however, the size of the covered population is, as yet, limited. Thus, MHOs are not yet generating the resources that have the potential to help improve the quality of service provision.

MHOs' potential for contributing to financial access and equity in the health system will depend on the percentage of the population covered, the contribution levels, and mechanisms for contributions established by MHOs. The contribution mechanisms of the MHOs in south Borgou suggest a rural model for improving access, by adapting to the level and timing of income among the target populations. In this case, MHOs only cover the benefits that are expensive. Through the establishment of mutual aid funds for members, now in an experimental phase, MHOs could contribute to improving members' access to services not covered by the benefit package. Moreover, the solidarity funds financed by village mutual organizations to handle benefits for the poor in their respective villages could contribute to improving equity at the local level.

Despite the newness of MHOs, evidence suggests that they could contribute to improving health system management at the local level. MHOs have already begun to approach health authorities regarding parallel payments and the treatment of the sick by health care staff. In addition, one of the MHOs in south Borgou, the Sirarou MHO, has been eager to meet with the management of the referral facility in order to improve the quality of maternity services for its beneficiaries. MHOs could, therefore, evolve into organizations that manage health care consumption as well as monitor service quality problems, a function that does not yet exist in the local and national health systems of the subregion.

The experiences of the MHOs of south Borgou, which benefitted from technical support from the International Center for Development and Research (ICDR), contrast with the difficulties encountered by the MHOs of Gbaffo and Porto-Novo, where implementation was not accompanied by technical support. This difference suggests that MHOs will need consistent support. Although the values of solidarity and mutual aid are still strong among broad sectors of Benin's population, the experiences of Gbaffo and Porto-Novo suggest that the initiatives to build viable MHOs solely on the basis of such values will be insufficient. MHOs will need national support and reinforcement in the area of the mutualization of health risk. Thus, the following recommendations are made to help MHOs to develop strategies for the mutualization of health risk.

1. Develop a policy framework wherein the health system responds to the values and principles that are closest to the population, supports diversity and adaptability to local circumstances, strengthens the role of the community in managing its own health, and incorporates the mutualization of health risk into its strategies to combat poverty.

2. Evaluate the technical assistance provided by the ICDR in south Borgou and the alternative support strategies of the Participation Institute of Benin to draw lessons for the development of a flexible technical support approach for establishing MHOs in the country.

3. Develop pilot MHOs in several regions to expand the base of MHO experience and to support the process of developing the strategy for mutualization of health risk in the country.

4. Establish a flexible legal framework that provides the basis for the legal status of MHOs and guarantees their autonomy.

5. Strengthen the coordination and synergy of interventions by aid agencies in the development of MHOs in the country.

2. Côte d'Ivoire

In the early 1990s, health sector reform became a central concern in Côte d'Ivoire. To address a series of constraints on public funding, the government developed a policy, the Human Resources Development Policy (PDRD-May 1991) whose fundamental objective was to *improve the population's standard of living and welfare through a better quantitative and qualitative balance between supply and demand in the areas of health, education and employment.* A number of operational objectives included the *mobilization of new resources while addressing equity concerns,* specifically, in the introduction of cost recovery from beneficiaries. However, government authorities realized that the implementation of cost recovery would also necessitate the establishment of regulatory mechanisms to protect vulnerable groups. Thus, incentives were given to mutual insurance systems as a way to cover the population's health needs while protecting vulnerable groups.

The guidelines defined by the Human Resource Development Policy are to be progressively implemented in upcoming years. A National Social Security Commission (C.N.S.S.) was created by decree 94-301 in June 1994. The findings of the Commission's work were submitted on March 23, 1995 in a document titled "Policies and strategy for a new line of health insurance in Côte d'Ivoire." This work led to the adoption of a *self-financed health insurance program* aimed at socialized management of medical coverage through the mutualization of the risks to be covered. Mutual health organizations (MHOs) were sanctioned in a policy document of the Ministry of Health (National Health Development Program 1996-2005) that promotes mutual-type organizations, with a local base but gradually becoming federal.

The contribution of MHOs to financing, benefits and access to care in rural areas was evaluated based on a study of four communities located to the far north of Côte d'Ivoire along the Malian border, in the communes of Kolia, Kouto, M' Bengué and Niellé. In Côte d'Ivoire, the rural agrarian population is essentially organized into cooperatives. The cooperative movement developed through a large network of Cooperative Vocation Groups (GVCs) n the coffee, cocoa and cotton sectors. On behalf of their members, GVCs ensure the collection and marketing of products on the one hand and the distribution of agricultural inputs on the other.

Cooperatives are thus an essential part of rural life. The 3,324 GVCs established in the coffee-cocoa sectors in the forested areas and in the cotton, rice and soy sectors in the savannah area make up most of the rural organizations. These GVCs represent 95% of the cooperative movement and involve close to 400,000 members, or 40% of the agrarian population. They insure the collection and primary marketing of 25% of coffee-cocoa and 99% of cotton, and the marketing of rice and soy in the northwest.

Located in the heart of the cotton area, Kolia, Kouto, M' Bengué and Niellé are characterized by the importance of cotton in local economic life. This profitable crop provides: (i) 60% of the average farmer's income in Niellé, (ii) 58.5% of the average farmer's income in M' Bengué, (iii) 48.5% of the average farmer's income in Kolia, and (iv) 44.5% of the average farmer's income in Kouto. This economic zone is generally described as a poor area with an average monthly income of 58,053 CFAF in Niellé, 43,446 CFAF in Kolia, 33,160 CFAF in M' Bengué, and 25,513 CFAF in Kouto.

The existence of a network of various cooperatives favors the construction of MHOs. It is probable that these communities may have also taken the initiative in financing health care or, at the very least, may have considered putting together the resources needed to manage the costs of health benefits. Although communities clearly need medical coverage adapted to their lifestyle and incomes, no mechanism capable of helping them bear the burden of illness has been set up. Except for groups of growers, there are few associations designed to help members in times of difficulty. When they do exist, such associations make only marginal allocations for health expenses. While professional organizations (primarily the cooperative vocational groups) do have a financial base that could be used to meet social health objectives, they have never organized to respond to the health care demands of members and their families.

These needs are real, however, and are apparent to cooperative leaders. In fact, more than 75% of those interviewed during the survey admitted to having "some difficulty" paying the costs of care and 47.5% admitted doing so "with great difficulty." It is also essential to note that the perception and the expectation of the population of MHOs is that they reduce the cost of health benefits (74.2%). The population's ability to pay is weak: 70% of the sample state that they can't afford an annual contribution rate above 1,000 CFAF and 80% estimate that their contribution cannot exceed a ceiling of 2,000 CFAF.

Local leaders have not shown an inclination to allocate resources toward health benefits. Faced with pressing and multiple needs and having only limited resources, local councils may even strike balances prejudicial to health. Competing priorities and limited resources have meant that local councils allocate little of their operational budget to health.

In conclusion, while the demand for medical coverage is very strong, none of the organizations active in the survey area has developed adequate responses to address health needs. GVCs, which could develop health financing activities, have not taken the initiative to redeploy their activities in areas of concern to their members. Such initiatives would constitute a major challenge for these structures, which have so far been limited to the tasks of collecting and marketing agricultural products. The failure of these organizations to respond to their members' needs has resulted in lost credibility. Their future survival may even depend on the diversification of their activities and the expansion of the range of services provided to members. They should be responsive to initiatives aimed at giving them authority and capability in the area of health insurance. Finally, town councils have a considerable role to play, either within the limits of the community or from an inter-community perspective, by offering a more effective framework for sharing resources and risks.

Urban areas have particularly rich networks of associations, such as neighborhood associations, citizen associations (ethnic in nature), denominational associations, etc. These associations reflect a tradition of building solidarity to confront social risks, like illness, death, loss of employment, indebtedness, or even pregnancy. The sample of associations on which the study is based includes associations of young people, women and associations open to people regardless of sex, age, or social or ethnic background.

The five mutual associations studied have generated a total 8,231,580 CFAF annually. The mutual organization, Le Cercle des Amis de la rue Dimbokro (C.A.R.D) has had the best performance with a volume of receipts of 4,919,360 CFAF, while the *Intimes du Nouveau Quartier* only collected 646,280 CFAF.

Average overall expenditures for health coverage among the 5 mutual organizations amount to 167,945 CFAF, or only 2% of the total contributions received. The contribution rate for health varies considerably from one association to the next. The *Intimes du Nouveau Quartier* devote 8.6% of their resources to health care, compared to 1.05% for C.A.R.D. L'Amicale de la Bagoué (A.M.I.B.A.) represented the middle, mobilizing 4.3% of its funds to finance health benefits. The mutual organization that allocates the most for health, in this case the *Intimes du Nouveau Quartier*, is also the one with a quota system providing that 55% of available resources be allocated for health. Such an allocation requirement assumes that the group has decided to make health concerns a priority.

The average volume of financial flows allocated to "death" is three times larger than the allocation for health: 520,060 CFAF (compared to 167,945 CFAF), or 6.4% of receipts (compared to 2%). But, it is in the "Others" category (i.e the line of expenses called "social" in the sense that they relate to social obligations such as marriages, baptisms, and various customary ceremonies) where we see the greatest concentration of resources. As a whole, the five mutual organizations allocate 730,000 CFAF in this area, or 9% of the contributions received. This priority is characteristic of all the mutual organizations, including the *Intimes du Nouveau Quartier,* which gives preference to financing health.

Even though health allocations are limited, there is a need for specific organizational provisions and a discussion among members on the techniques for handling health risks. It is obvious that targeted support will be necessary to better cover health risks. The mutual organization movement can no longer rely on voluntarism to provide services. The challenge now is to build on experience and create incentives to transform interested mutual organizations into health care financing providers. A strategy should be developed to provide support for mutual organizations to develop the technical knowledge necessary to act as a health insurance system and improve access for vulnerable groups.

Regarding conventional providers of health care financing, a gap exists between the mutual organizations set up by salaried government employees and the prevailing situation in the private sector. Let us take, for example, the General Mutual Health Organization of Government Officials and Agents (MUGEF-CI). The financial situation of MUGEF is characterized by a persistent chronic structural deficit. From 1991 to 1996, revenues went from 5,269,945,596 CFAF to 8,551,653,558 CFAF. These revenues include: (i) contributions collected, (ii) financial income, (iii) other income. Expenditures, which are split between technical expenditures (benefits paid) and expenditures for administrative management (operational and investment expenditures) have grown from 7,663,921,754 CFAF (1991) to 10,738,662,913 CFAF (1996).

The motivation behind the creation of MUGEF was to help government officials and agents obtain better care, assuring the partial payment of pharmaceutical costs, dental care and prostheses and corrective lenses. Some improvement in this population category's access to health care has resulted. Because MUGEF-CI contributions are not calculated on the basis of the health status or age of the participant, but rather on their salary or pension, it has made a major contribution to reducing inequities between lower and higher officials, the sick and the healthy, active employees and retirees. To overcome the current crisis, those in charge are advocating, by means of a 3% to 8% increase in the contribution rate, expanding health coverage to include doctor's visits, hospitalization, and pregnancy. One must examine, however, whether the conditions for such steps exist.

Except for MUGEF-CI, conventional financing providers only deal with the small-company mutual organizations that offer health coverage based on the status of the participant (senior manager or worker) and the company's profits. This narrow range of financing is not representative of the mission of true MHOs. One of the more recent attempts to build an MHO not linked to an interest group is that of the General Social Assurance Mutual of Côte d'Ivoire (GMPS), which offers death benefits in addition to health coverage. GMPS provides six levels of coverage with monthly contributions ranging from 5,500 CFAF to 25,000 CFAF. Health care is dispensed in subsidized clinics and hospitals. As of the survey date, GMPS had 101 members and 959 beneficiaries.

To summarize, the contribution of the case study mutual organizations to health care financing has been weak in Côte d'Ivoire. A study of MHOs would be even weaker without the presence of MUGEF-CI which, despite its structural weaknesses, is a mutual organization that has made considerable contributions to improved access to health care and the reduction of inequities among different categories of employees. Fundamentally, the inadequate funding and low priority given to health render these organizations marginal. Rural communities have not brought forth credible options for health coverage, even though economically speaking, such initiatives are conceivable. Urban mutual organizations, on the contrary, are making commendable efforts to cover health needs through mechanisms and agencies with well defined management and scope. There is a collective understanding of the importance of health and its management, but the financial support to the sector is still insignificant.

The case studies of mutual organizations in Côte d'Ivoire demonstrate that while civil society may support health promotion, its mutual organizations are not defining and implementing mechanisms and policies on their own initiative to cover health risks. Expenditures for health face strong competition from other types of expenditures that households deem much more socially useful. Reforms such as decentralization do not necessarily provide new resources for health, in that local councils decide where to invest local finances. However, by building on community initiatives through education, training, and advocacy, existing mutual organizations can develop into MHOs that improve access to health services.

03. Ghana

MHO development is a relatively recent phenomenon in Ghana. This is related to the previous tradition of free publicly provided health care, which continues for most employees in the formal sector up to now, although the trend is toward reduction of the amount of free health care cover offered by government and employers to their employees, in efforts to contain health care costs.

The modern concept of insurance is still little understood among the general population, or tends to be associated only with vehicle and other property insurance. Moreover, traditional solidarity tends to lack inclusivity to the extent that such solidarity is frequently limited to clan or ethnic organizations and tends to break down beyond those boundaries.

Meanwhile the evidence examined in this paper indicates that development of MHOs is hampered by lack of suitably skilled personnel and in particular lack of knowledge of the specific risks associated with health insurance and appropriate risk management techniques.

The case study analysis in this research shows that non- or low-participatory schemes such as the West Gonja one appear primarily focused on cost recovery or financial objectives, giving the impression that health improvement is only incidental to their aims, in contrast to participatory schemes (like the Community Partners for Health schemes in Nigeria) which tend to place emphasis on health improvement and quality of care. Some of the problems of the West Gonja Scheme which are aggravated by its non-participatory character include evidence of significant adverse selection and moral hazard.

In this connection, the participatory or ‘complex’ model of community financing seems better placed to respond to these kinds of problems principally due to the significant level of community participation in their management. These latter schemes are also more likely to make a significant efficiency contribution by focusing available resources on PHC services and the health care priorities of the community concerned. The features of the proposed DHIS system in Ghana appear to be based on these lessons and, if implemented, will make a useful contribution to MHO practice in the country.

The health financing aspect of professional organizations such as the teachers association is not well developed, mainly because the members of such organizations typically benefit from subsidized or free health care conditions from the government. But there is considerable potential for these kinds of funds to play a crucial role in health care financing so long as the government continues in its present course of gradually reducing health care benefits for the public sector (although it is also possible that the proposed national health insurance scheme will make their role redundant).

Government plans for introducing a national health insurance scheme by stages will significantly impact on MHO development in the country. But non-profit mutual insurance schemes may still have a comparative advantage in providing for the informal sector (including the large rural population) where Government will have great difficulty devising sufficiently efficient and effective ways of collecting premiums and avoiding abuse. The experience being

accumulated by the MHOs in these areas is being closely followed by the government and it can be assumed that this will not be ignored when thought is given to extending social insurance to the non-formal sectors.

Because of the last point, concentration on the health activities and sectors of the population which will not be covered (at least initially) by the proposed phased introduction of national health insurance scheme (which means mostly the informal sector including rural communities) will be the right direction in which to develop MHO interventions.

The weaknesses of the low participation model (e.g. West Gonja and Nkoranza schemes) highlighted in the study implies that they could benefit from targeted technical assistance. The areas where such support might be useful would be: lack of independence from the provider, lack of negotiating power, marketing, need for quality control mechanisms, drugs' policy, and lack of preventive/promotive services.

There is need for legislation to enable mutuals to acquire a legal or corporate status through registration, to offer protection for members who subscribe and pay dues, to regulate financial management and administration, and may be some model rules and regulations (drawn up in consultation with existing mutuals) which new organizations can adopt or adapt to their own needs.

04. Mali

Since 1991, Mali has been embarked on the road to democratization and decentralization. This context favors the development of private initiative, particularly the opening up of civilian society and ventures in social economics.

In the area of health, the 1990s were marked by budgetary constraints and the decision by the Malian government to open up the health care system. Measures were taken to authorize the private practice of medicine, to put an end to the principle of free health care, and to end the government monopoly over imports of medications. Following the Bamako Initiative, the population was given more responsibility for the financing and management of primary health care, particularly through cost recovery and the sale of essential medicines.

In Mali, this policy took shape in the creation of community health centers, managed by the communities themselves through ASACOs (Community Health Associations). This development, along with the campaign to diversify the supply of health care, led to discussions on financing care through mutual benefit organizations. Some concrete experiments have been carried out, including the creation of the Mutual Health Organization for Workers in Education and the Arts (MUTEC). A national framework favorable to the development of mutual insurance systems was put in place, as Mali passed a law on mutual insurance systems in 1996 and began the creation of an agency to support the development of mutual insurance systems in Mali.

The inventory of mutual health organizations (MHOs) carried out identified fifteen MHOs operating in Mali. These are primarily groupings of public sector employees that have not initially covered health risks, but instead serve as mutual aid funds. They could, however, evolve into mutual health organizations in the future.

What can we draw from the two case studies presented? Though the current role of MHOs in the financing and provision of health care is quite limited, their potential is important in Mali, both in rural and urban areas, in the coverage of large and small risks. Current conditions in Mali are favorable to their expansion and development.

MUTEC has achieved its objective of offering its members quality health care at lower cost, and has even added preventive care and health promotion services. Health services are functioning well and are financially viable. However, MUTEC has experienced difficulties in developing solidarity and risk sharing among members through its subscription practices. The regular recovery of contributions will be difficult to sustain over the long term under a voluntary system, unless an automatic salary deduction can be put in place.

MHOs can help to address deficiencies in the health care system, such as health services being to distant from members, inadequate quality of care and patient handling, and fees being too high. By entering the health care provider arena, MHOs can play an innovative, pioneering role in defining quality standards and regulating market prices (keeping them as low as possible consistent with their non-profit status) through negotiations with providers. In this way, MHOs can contribute to the democratic management of the health sector.

Changing circumstances should lead to MHOs to modify the services they provide, as they must always be attentive to their members' concerns and expectations. In the case of MUTEC, we see that the recent diversification of the supply of health care close to Bamako is leading the health center to reposition itself to offer more specialized services, an increased role in health insurance and in organizing associations between its members and other health centers that contract with MUTEC.

The MUTEC case study also shows the importance of having a rapid and efficient management information system to guide decision-making. Particularly crucial for managing the MHO are up-to-date patient records, information on contributions, and monitoring of expenditures per member.

The second case study looked at a collective management system for referrals and evacuation to the health district hospital (Kolokani) using the ASACOs (Community Health Associations). This system makes the demand for specialized care cost-effective by spreading the financial risk associated with hospitalization over the entire population of areas covered by community health centers.

With some adjustments to this system (clearer rate structure, more equitable contribution system, creation of a mutual structure representing the ASACOs, a contractual relationship between this mutual organization and the hospital), this case demonstrates that the ASACOs existing nearly everywhere in Mali and responsible for organizing basic health care represent fertile ground for the creation of regional mutual insurance systems to cover large risks.

ASACOs could be considered incipient mutual insurance structures that can join together at the district level to jointly manage the relationship of their members and the district hospital. As they are already involved in the provision of basic health care and in referrals, ASACOs are generally trusted in their communities. They are also are proven to be capable of generating funds from their users and of maintaining social control to contain fraud and abuse. In addition, the collective subscription of all users of a community health center under a district-managed hospital insurance plan would make it possible to avoid adverse selection and to spread heavy risks over a large group of individuals. These arguments make the ASACOs strategic partners for the implementation of mutual health organizations in rural areas. asf.,jSDFA Sasdrfauseramre. AfxThe work plan outlined in the pages that follow includes 16 strategies for realizing the overall objeassistance will be required.

5. Nigeria

Nigeria contains nearly a quarter of Africa's total population. Yet, this giant country remains relatively isolated, largely because of the political character of the regime there. Thus even developments in the non-governmental sector of this big country have generally gone unnoticed. It will therefore come as a surprise to many to learn that there are not only mutual health organizations (MHOs) in Nigeria but that they may even have useful experience to impart to others elsewhere.

Hence one of the useful outcomes of this mission is the fact that it helps to focus attention on this experience, and the study indeed shows that the Nigerian experience has several interesting features and a contribution to make to the body of African practice and knowledge in this field. The main MHOs studied, which offer useful lessons, are the Community Partners for Health (CPHs) promoted by USAID's BASICS programme in that country, and the Country Women's Association of Nigeria (COWAN).

The are several innovative features of the Community Partners for Health (CPHs) worth highlighting. First is that, they are organized through existing community based organizations (CBOs) of all kinds – such as local trade unions, petty traders, associations of blacksmiths, carpenters, battery chargers, other professional associations, residential and tenants' associations, church groups including spiritual or charismatic church groups, Muslim groups, traditional birth attendants, etc. Membership of the CPH is gained not directly as an individual but through the local association which offers advantages in terms of social control and prevention of abuse, fraud, etc. as well as the chasing up of defaulters and minimizing adverse selection. It also means that control is exercised at the lowest possible level.

A second feature worth noting is the savings nature of the schemes, rather than reliance on an insurance mechanism. The idea of saving for health is apparently better understood (as an extension of traditional saving concepts such as *esusu* or *ojo*), whereas insurance is less well understood, and moreover, requires different and rather scarce skills to manage properly. This particular adaptation not only saves on administrative costs (for the CPH), but also helps avoid fraud, an ever-present danger with insurance schemes everywhere and a big problem in Nigeria. These remarks apply equally well to the COWAN Mutual Health Savings scheme too.

A third important feature is that the scheme is based on a preliminary identification of the top ten health priorities of the community concerned (the CBOs are involved in this preliminary task), which then form the focus of the interventions of the CPH's primary health care activity, i.e. the health providers in the network agree to offer 50% discount to CPH members for those defined priority areas. This is a good design feature aiding in the achievement of improved access to health care, equity and efficiency.

The CPH model and experience offer other lessons too. One of these is the formal separation of the health facilities from the CPH through contracts and negotiation (Memoranda of Understanding). This separation is essential for reasons of efficiency, effectiveness and quality of care.

Another is the setting of quantifiable objectives for the CPH to achieve (this aids the budgeting, planning, monitoring and evaluation process immensely).

One of the principal conclusions from the Nigerian case studies is therefore that the 'complex' or high participation model of community financing (i.e. the CPH type of scheme) appears well attuned to the health care needs of the communities and health sector goals of the country. Social movement based schemes such as the COWAN scheme may also have good potential, and it is no coincidence that both types (social movement and participatory community financing) share broadly similar features in so far as participation by the insured or their representatives in management is concerned. These participatory features may be the key to their relative success (or potential to do so, as arguably in the case of COWAN) but unlike the CPH, COWAN cannot negotiate terms and influence quality and efficiency of providers because it has no links with providers (except its own clinics).

The COWAN model has the advantage that it is based on a traditional institution (credit and savings) which has wide legitimacy and is easily understood. Its potential for generating resources for health care is therefore arguably quite good. However, the COWAN experience probably suffers from excessive caution in regard to the actual level of contributions and the conditions of access to the savings.

The potential indigenous institutional support for a mutuals development programme in Nigeria appears to be quite good; however, there is only limited external (donor and other) support available due to existing political constraints.

Technical assistance to existing MHOs to equip them better to manage their schemes (e.g. in accounting and record-keeping, with the skills to carry out monitoring and evaluation of their work, and with the skills to run an insurance scheme) is another clear area of need. The analysis shows that the Nigerian schemes would also benefit from targeted training in these areas: need for independence from the provider (CPHs), use of negotiating power, marketing, need for quality control mechanisms, and drugs' policy.

The room for MHO development in Nigeria lies in the sectors of the population that will not be covered (at least initially) by the proposed phased introduction of the national health insurance scheme (which means mostly the informal sector including rural communities).

6. Senegal

The three mutual health organizations (MHOs) selected for the case studies presented from Senegal provide an overview of different experiences in Senegal. They are distinguished both by the types of people covered and the extent of their protection. These varying initiatives could be developed and reproduced throughout the country, and could even serve as models for the development of the mutual insurance movement.

Some of the case studies' findings are presented in the following sections.

In the area of benefits, all of the three MHOs insure members for hospitalization, but to differing degrees. Low risk services, such as medical visits or pharmacy services, are more and more accessible, as the expansion of health centers and generic medicines reduces the cost of health care. Benefits can be handled through savings, family ties or traditional mutual aid. By contrast, these MHOs show their limitations in the case of more costly care, i.e., in the area of hospitalization. Sometimes mutual health organizations cover all benefits associated with hospitalization; sometimes they exclude surgery for financial reasons.

The level of coverage varies according to the needs of the population and the resources available. For example, the MHO for Education Volunteers ensures all hospitalization benefits at 100% in exchange for a high contribution (10,000 CFAF per person per year). The FAGGU MHO offers complementary coverage because retirees already benefit from health insurance through the Senegalese Retirement and Contingency Institute (IPRES). The Lalane Diassap MHO has had to limit its coverage to 15 days of hospitalization for financial reasons.

Populations covered by the three mutual health organizations represent different social classes within Senegalese society: farmers, retirees from the modern sector, volunteers (temporary status before becoming a civil servant). While these MHOs do not represent all social categories, their experiences could be reproduced among social groups with certain similarities: income, organization, lifestyle, etc.

Despite totally different circumstances, some difficulties are common to all the case study MHOs. First, the contributions recovery rate is inadequate (except for the volunteer's mutual health organization since there is withholding at the source). In the best of cases, 60% of the members are up to date with their contributions. This situation is to some extent due to the participants' limited ability to contribute, but also due to members overlooking payment. Those collecting the contributions should work closer to their members in order to reduce late payment. If MHOs cannot automatically deduct contributions from members' salaries, it will be essential to have adequate field presence to ensure that contributions are made.

All the MHOs lack material resources for day-to-day management (site, computers, vehicle, etc). Office administration is still manual, whether for accounting or for maintaining records on members and beneficiaries. This situation does not rule out the viability of MHOs, but it does hinder their development and effectiveness.

On the whole, the general principles of mutual organizations seem to be understood by the managers of the MHOs studied. However, these individuals need specific training and support in

targeted areas, such as the principles of management and accounting. Even though books are kept up regularly, accounting procedures are poorly adapted and do not allow for a reliable assessment of the financial health of the MHO.

Finally, in terms of administrative management, it is essential that the mutual health organizations have a registry of beneficiaries and monitor the evolution of benefits. In small or rural organizations, social control is very strong and compensates for a tenuous estimate of the list of mutual organization members. By contrast, in mutual health organizations that are large or cover an entire territory, the monitoring of beneficiaries is a *sine qua non* of success. Here, manual record keeping quickly becomes tedious and impracticable; the only conceivable solution is to computerize.

With respect to monitoring benefits, it is important to be able to produce statistics on the changes in the consumption of medical services. Of the three MHOs studied, two of them have begun to record some data on hospitalization but they are not being optimally used. Monitoring and supervision will be essential to avoid potential deviations and to analyze the changes in demand and utilization by the MHOs' members.

Viability Criteria

The case studies indicate that the members' ability to contribute is not the essential factor in the success of the mutual health organization. Some MHOs manage to pay for considerable benefits with very limited contributions. On the other hand, there must be a strict assessment of the level of benefits offered in comparison with the resources available. Significant growth in medical consumption must be anticipated in the early years of operation, as the implementation of health coverage significantly changes behaviors, with utilization rates stabilizing only some years later. The experience of the three case study MHOs is very informative regarding the relationship between MHOs and access to services and utilization.

There are other essential elements to the viability of a mutual health organization. Management must be accountable, committed and trustworthy. Even the slightest doubt about the integrity of the management may be a factor in the failure of the organization.

In addition, social control and the proximity of those in charge to the organization's members play very important roles. They limit delayed contributions and reduce cases of abuse and fraud. Social control must obviously be accompanied by effective management.

The more educated the population is about MHOs, the higher the rate of penetration is likely to be. The Lalane Diassap MHO is a good example of success in this area.

Finally, MHOs must, as much as possible, reach agreements with health care providers. This allows them to obtain rate reductions, to make direct payments, and to control the consumption and quality of medical care. Without such agreements, mutual health organizations with very few resources like Lalane Diassap will not be viable. The rate reductions which it enjoys allow it to provide significant protection to a population with limited ability to pay.

MHOs do not yet seem to be participating in decisions concerning health and improved quality of care. The mutual organization movement may still be too new to play such a political role, however, MHOs should become involved as they develop.

Prospects

The three case study MHOs serve as examples for the development of the mutual organization movement in Senegal. Their experiences may be replicable in other sectors or population groups similar to the areas of involvement of these three MHOs.

The MHO for Education Volunteers targets an educated population. This population has average income and temporary status but will become civil servants or salaried employees in the modern sector. Their situation could be compared to that of students, for example. Their experience could be used to envision the implementation of university mutual health organization. In addition, the Volunteers population could serve as resource persons in promoting awareness of the mutual organization movement throughout Senegal.

The FAGGU MHO can be used as a model for the creation of complementary mutual organizations for other already insured people, primarily salaried employees in the modern sector and civil servants.

Finally, Lalane Diassap provides proof that an MHO can function despite its members' low and irregular incomes. This experience can be useful in rural areas, but also for the informal sector in urban areas.

The operating methods of the three MHOs could be adapted to other contexts and thus extend health coverage to most of the Senegalese population. To do this would require strong institutional backing and ongoing support measures. Of primary importance, however, it is necessary to disseminate these experiences to the public at large to promote and explain the principles of MHOs.

Initiatives must also be supported by training programs and other technical support, such as expert missions, assistance in implementing accounting procedures, actuarial support for definition of contributions and benefits, etc. These activities should be monitored regularly. Programs run by the Ministries or the BIT-ACOPAM/WSM-ANMC program can be the source of such supporting activities and local organizations such as the Thiès committee can serve as staging posts.

Pairing agreements can also be foreseen with International mutual health organizations. These would bring institutional recognition, an exchange of know-how, and potentially material and technical assistance to Senegalese MHOs.

We do not consider the implementation of a precise legal framework for MHOs as a priority as of now. The development of the mutual health organization movement is still too recent and limited; the adoption of a law could curb initiatives and constrain their growth. However, this issue is on the agenda and existing initiatives must be analyzed in depth so as not to adopt an inappropriate model.

The mutual health organizations of Senegal have already proven themselves and are likely to develop rapidly. Their experiences must be disseminated and their activities supported.

Annex A: List of MHOs Investigated by Country (Inventory and Case studies

To facilitate the reading of the paper, this annex provides a complete list of the MHOs in this study, coded for easy reference. Coding is by country and number, for instance, Mali [3] refers to MEUMA; Senegal [3, 21] refers to Lalane Diassap and Bok Jef.

Benin

Sirarou UCGM (l'Union communale des groupements mutualistes de sirarou (UCGM Sirarou))
Sanson UCGM (l'Union communale des groupements mutualistes de sanson (UCGM Sanson))
Ilera MHO (Mutuelle Ilera de Porto Novo-Mutuelle du cabinet médical St Sébastien)
Alafia MHO (Mutuelle Alafia de Gbaffo)

Burkina Faso

Dakwena MHO (Mutuelle Dakwena)
Famille Tounouma (Mutuelle pharmaceutique de la sainte famille tounouma)
MUATB (Mutuelle des agents du Trésor du Burkina)

Cameroon

AFFERAZY (Association des filles et femmes ressortissantes de l'arrondissement de Zoétélé à Yaoundé)
Babouantou (Caisse de solidarité Babouantou de Yaoundé)
BACUDA (Batibo Cultural and Development Association)
MNE (Mutuelle nationale de l'¾ducation)
MPOUAKONE
MUPEHOPROMA
Les Amis (Association des amis clan d'âge no. 13)
NSO-NGON
POOMA (Yaoundé)
SAWA (Association des ressortissants SAWA de Yaoundé)

Côte d'Ivoire

MUGRACE. (La Mutuelle générale des résidents d'Abobo centre-commune d'Abobo)
CARD (Le Cercle des amis de la rue de dimbokro-commune de Marcory)
AMIBA (L'Amicale de la Bagoué-Commune de Koumassi)

MC 36 (L'Amicale des mamans du Canal 36 (Commune de Youpougon)
Les Intimes (Les Intimes du nouveau quartier)
MUGEF-CI (La Mutuelle générale des fonctionnaires et agents de l'¾tat)

Ghana

West Gonja (Community Financing Scheme for Admissions, West Gonja)
Teachers' Funds (Teachers' Welfare Funds)
Dagaaba Association (Duayaw Nkwanta Dagaaba Association)

Mali

MUTEC Health Centre (Centre de santé de la MUTEC)
Kolokani (Centre de santé de référence du cercle de Kolokani, that is, Reference Health Center of the Kolokani circle or zone)
MEUMA (Mutuelle des étudiants et universitaires du Mali)
MUTAS (Mutuelle des travailleurs de l'action sociale et de la santé)

Nigeria

COWAN (Country Women's Association of Nigeria Health Development Fund)
Lawanson CPH (Lawanson Community Partners for Health)
Jas CPH (Jas Community Partners for Health)
Ibughubu Union (Ibughubu Improvement Union)

Senegal

Education Volunteers (Mutuelle des volontaires de l'éducation)
FAGGU (Mutuelle FAGGU)
Lalane Diassap (Mutuelle de Lalane Diassap)
Dimeli Yoff
Multi Assistance de l'‹ducation
Mutuelle Sococim Entreprise
Fandene
FISSEL
KOUDIADIENE
Menagères de Grand Thiès
Mont Rolland
Ngaye Ngaye
Saint Jean Baptiste
Sanghe
Darou Salam
Mboro
Pamdienou Lehar

Thially
Nimzatt-Kaolack
RJOK (Regroupement de jeunes ouvriers de Kaolack)
Bok Jef
Keur Maloum
Koundam
Mutuelles des enfants de la rue

Togo

ACB (Association des couturières de BE)
Sages Femmes (Association des sages femmes du Togo)
Djagbagba
GMC (Groupement mutuel des cadres)
Mutuelle OTP (Office Togolais des phosphates)
Affaires Sociales USYNCOSTO (Union syndicale des coiffeuses de style du Togo)
MUCOTASGA (Mutuelle des conducteurs de taxi motos de la station Gaitou)
MUSAD (Mutuelle de santé ADIDOADE)
MUSA-CSTT (Mutuelle de santé-Confédération syndicale des travailleurs Togolais)

Countries in the Study
Benin, Burkina Faso, Cameroon, C^te d'Ivoire, Ghana, Mali, Nigeria, Senegal, Togo
Case Study MHOs
1. Sirarou UCGM (l'Union communale des groupements mutualistes de Sirarou (UCGM Sirarou))
2. Sanson UCGM (l'Union communale des groupements mutualistes de Sanson (UCGM Sanson))
3. Ilera MHO (Mutuelle Ilera de Porto Novo-Mutuelle du cabinet médical St Sébastien)
4. Alafia MHO (Mutuelle Alafia de Gbaffo)
5. MUGRACE. (La Mutuelle générale des résidents d'Abobo centre-Commune d'Abobo)
6. CARD (Le Cercle des Amis de la Rue de Dimbokro-Commune de Marcory)
7. AMIBA (L'Amicale de la Bagoué-Commune de Koumassi)
8. MC 36 (L'Amicale des mamans du Canal 36 (Commune de Youpougon)
9. Les Intimes (Les Intimes du nouveau quartier)
10. MUGEF-CI (La Mutuelle générale des fonctionnaires et agents de l'¾tat)
11. West Gonja (Community Financing Scheme for Admissions, West Gonja)
12. Teachers' Funds (Teachers' Welfare Funds)
13. Dagaaba Association (Duayaw Nkwanta Dagaaba Association)
14. MUTEC Health Centre (Centre de santé de la MUTEC)
15. Kolokani (Centre de santé de référence du cercle de Kolokani i.e. Reference Health Centre of the Kolokani circle or zone)
16. COWAN (Country Women's Association of Nigeria Health Development Fund)

17. Lawanson CPH (Lawanson Community Partners for Health)

18. Jas CPH (Jas Community Partners for Health)

19. Ibughubu Union (Ibughubu Improvement Union)

20. Education Volunteers (Mutuelle des volontaires de l'¾ducation)

21. FAGGU (Mutuelle FAGGU)

22. Lalane Diassap (Mutuelle de Lalane Diassap)

Inventory MHOs

1. Ilera MHO (Mutuelle Ilera de Porto Novo-Mutuelle du cabinet médical St Sébastien)

2. Dakwena MHO (Mutuelle Dakwena)

3. Famille Tounouma (Mutuelle pharmaceutique de la sainte famille Tounouma)

4. MUATB (Mutuelle des agents du trésor du Burkina)

5. AFFERAZY (Association des filles et femmes ressortissantes de l'arrondissement de Zoétélé à Yaoundé)

6. Babouantou (Caisse de solidarité Babouantou de Yaoundé)

7. BACUDA (Batibo Cultural and Development Association)

8. MNE (Mutuelle nationale de l'¾ducation)

9. MPOUAKONE

10. MUPEHOPROMA

11. Les Amis (Association des amis clan d'âge no. 13)

12. NSO-NGON

13. POOMA (Yaoundé)

14. SAWA (Association des ressortissants SAWA de Yaoundé)

15. MUTEC Health centre (Centre de santé de la MUTEC)

16. MEUMA (Mutuelle des étudiants et universitaires du Mali)

17. MUTAS (Mutuelle des travailleurs de l'action sociale et de la santé)

18. Education Volunteers (Mutuelle des volontaires de l'éducation)

19. FAGGU (Mutuelle FAGGU)

20. Lalane Diassap (Mutuelle de Lalane Diassap)

21. Dimeli Yoff

22. Multi assistance de l'¾ducation

23. Mutuelle Sococim entreprise

24. Fandene

25. FISSEL

26. KOUDIADIENE

27. Menagères de Grand Thiès

28. Mont Rolland

29. Ngaye Ngaye

30. Saint Jean Baptiste

31. Sanghe

32. Darou Salam

33. Mboro

34. Pamdienou Lehar

35. Thially

36. Nimzatt-Kaolack

37. RJOK (Regroupement de jeunes ouvriers de Kaolack)

38. Bok Jef

39. Keur Maloum

40. Koundam

41. Mutuelles des enfants de la rue

42. ACB (Association des couturières de BE)

43. Sages Femmes (Association des sages femmes du Togo)

44. Djagbagba

45. GMC (Groupement mutuel des cadres)

46. Mutuelle OTP (Office Togolais des phosphates)

47. Affaires Sociales USYNCOSTO (Union syndicale des coiffeuses de style du Togo)

48. MUCOTASGA (Mutuelle des conducteurs de taxi motos de la station Gaitou)

49. MUSAD (Mutuelle de santé ADIDOADE)

50. MUSA-CSTT (Mutuelle de santé-Confédération syndicale des travailleurs Togolais)

Annex B: Summary of Main Features of Case Study MHOs

To facilitate the reading of the paper, this annex provides a complete list of the MHOs in this study, coded for easy reference. Coding is by country and number, for instance, Mali [3] refers to MEUMA; Senegal [3, 21] refers to Lalane Diassap and Bok Jef.

Summary of Main Features of Case Study MHOs						
Name used in this synthesis	**Country code and MHO founding date**	**Target group(s)**	**Titular membership (also beneficiaries and total target population)**	**Initiators/owners**	**Revenue generation mechanism**	**Services offered**
Education Volunteers	Senegal [1] Nov. 1995	Teaching volunteers recruited for 4 years each	Nov. 1995: 1,200 Nov. 1996: 2,400 Nov. 1997: 3,704 Compulsory; families excluded	Volunteers (but Ministry of Education gives technical backing)	Insurance	100% hospitalization including evacuations and surgery
FAGGU	Senegal [2] Oct. 1994]	Pensioners registered with the Institut de Prévoyance et de Retraite du Senegal (IPRES) in the Thiès region	814 out of 4,550 pensioners in 1997 approx. 3,500 beneficiaries out of potential 13,650 (at 3 beneficiaries per person)	Pensioners	Insurance	Hospitalization costs beyond IPRES cover, minus surgery
Lalane Diassap	Senegal [3] Jan. 1994	Villages of Lalane and Diassap and the Medina Fall sector of Thiès (all in the Thiès region)	189 in 1997 (989 beneficiaries out of total population of 1,200)	Initiated by youth association of Lalane, owned by members	Insurance	15 days maximum hospitalization, excluding surgery
MUTEC Health Center	Mali [1] Feb. 1990	Teachers and general population of Bamako and surroundings	833 subscribers in 1996; total target population unknown	MUTEC (Mutuelle des travailleurs de l'éducation et de la culture)	Insurance type subscription payments entitling subscriber to reduced tariffs at health center	PHC services of health center
Kolokani	Mali [2] Jan. 1997	Villages of Didiéni: (pop. 17,350), Massantola (pop. 6,717), Nossombougou (pop.14,942), Sabougou (pop. 11,820)	Around 50,000 out of potential population of 200,000	Health authorities of Kolokani (principally) in partnership with community health associations (ASACOs)	Insurance type subscription payments, community contributions (via ASACOs) and user fees	Hospitalization, including evacuation and surgery

Summary of Main Features of Case Study MHOs						
Name used in this synthesis	**Country code and MHO founding date**	**Target group(s)**	**Titular membership (also beneficiaries and total target population)**	**Initiators/owners**	**Revenue generation mechanism**	**Services offered**
Sirarou UCGM	Benin [1]1995	Villages under the commune of Sirarou	3,079 in 1996 out of target pop. of 13,000	Commune members	Insurance	Hospitalization, delivery, minor interventions, surgery and snake bites
Sanson UCGM	Benin [2]1995	Villages under commune of Sanson	584 in 1996 Total target pop. of 7,300	Commune members	Insurance	Hospitalization, delivery, minor interventions, surgery and snake bites
Ilera MHO	Benin [3]1996	Porto Novo town (approx. 100,000 inhabitants)	About 50 (1996)?	Centre Afrika Obota, and especially Dr. Paul Ayemona	Insurance	PHC services: consultation, drugs, delivery, laboratory services
Alafia MHO	Benin [4]1995	Village of Gbaffo (pop. approx. 2,000 or less)	Less than 100	Initiated by director of provincial hospital and staff of communal health complex but annual general assembly put in place	Insurance	Consultation at communal facility level (PHC) and admissions, plus surgery at reference hospital

Summary of Main Features of Case Study MHOs						
Name used in this synthesis	**Country code and MHO founding date**	**Target group(s)**	**Titular membership (also beneficiaries and total target population)**	**Initiators/owners**	**Revenue generation mechanism**	**Services offered**
COWAN's Health Development Fund	Nigeria [1] 1989	Rural women of Nigeria	No. of contributing groups (each of 5-25 members): 1992: 6,264 1993: 6,960 1994: 7,800 approx. 78,000 members assuming average of 10 members per group	COWAN	Savings (for health care loans to members)	Catastrophic illness (admissions, etc.)
Lawanson CPH	Nigeria [2] Dec. 1995	Peri-urban and deprived communities of Lagos	21 community-based organizations (CBOs) with estimated membership of 58,000	4 health facilities in partnership with (CBOs)	Savings, third-party subscription payments (with discounted pricing for subscribers)	PHC services
Jas CPH	Nigeria [3] Dec. 1995	Peri-urban and deprived communities of Lagos	13 CBOs with estimated membership of 10,000	1 health facility in partnership with CBOs	Savings, third-party subscriptions (with discounted pricing for subscribers)	PHC services
Ibughubu Union	Nigeria [4] May 1972	Members of Ibughubu village (in Anambra State of eastern Nigeria) living in Lagos	More than 300	Members	Contributions including insurance element	Hospital admission
West Gonja	Ghana [1] Oct. 1995	Inhabitants of West Gonja, catchment area of district hospital (total pop. of 120,000, but scheme being extended in phases)	Beneficiaries: Dec 1996: 6,169 Nov 1997: 13,360 (out of a potential population in 1996 of 25,000)	District hospital	Insurance	Hospitalization at 100%

Summary of Main Features of Case Study MHOs						
Name used in this synthesis	**Country code and MHO founding date**	**Target group(s)**	**Titular membership (also beneficiaries and total target population)**	**Initiators/owners**	**Revenue generation mechanism**	**Services offered**
Teachers' Welfare Funds	Ghana [2] 1992in Kintampo District	Teachers	Approx.1,000 in Kintampo; all teachers automatically members	Ghana National Association of Teachers, Kintampo Branch	Contributions with insurance element	Supplementary health care beyond that provided free by the government to teachers
Dagaaba Association	Ghana [3] 1996 (?)	Members of Dagaaba ethnic group living in Duayaw Nkwanta district and surrounding villages	82 members in 1997 with 160 beneficiaries	Members	Contributions with insurance element	Admissions
MUGRACE	Côte d'Ivoire [1] 1995 (?)	Residents of the Commune of Abobo in Abidjan, mainly informal sector people	About 40 members; all household members are beneficiaries	Initiated by unemployed, retired, and uneducated people; owned by members	Monthly contributions (insurance) and ad hoc contributions	Fixed allowance (FCFA 15,000) for hospitalized member and lower amount (FCFA 6,000) for minor illnesses
CARD	Côte d'Ivoire [2] Aug. 1993	Residents of the Rue Dimbokro or Avenue de Man in the commune of Marcory in Abidjan, but mainly youth membership	61 members; beneficiaries include all household members	Owned by members	Monthly (insurance type) contributions plus ad hoc contributions	Fixed grant for hospitalizations
AMIBA	Côte d'Ivoire [3]1994	Mainly informal sector at Bagoué in the commune of Koumassi in Abidjan	192 members; spouses also benefit from medical coverage	Owned by members	Monthly (insurance) dues	Fixed allowance for hospital admission costs for member or spouse

Summary of Main Features of Case Study MHOs						
Name used in this synthesis	**Country code and MHO founding date**	**Target group(s)**	**Titular membership (also beneficiaries and total target population)**	**Initiators/owners**	**Revenue generation mechanism**	**Services offered**
MC 36	Côte d'Ivoire [4]Jan. 1994	Women of the formal (e.g., secretaries, teachers) and informal (e.g., housewives, retirees, traders) sectors of Canal 36, Abidjan	40 members (nonhealth care benefits extended to other relatives)	Owned by members	Monthly (insurance) dues plus ad hoc contributions	Fixed amount (FCFA 15,000) for hospital admission and lesser figure (FCFA 6,000) for minor illnesses
Les Intimes	Côte d'Ivoire [5]1986	Open to all Abidjan residents, but in practice targets the "Nouveau Quartier"	126 members; beneficiaries include wide range of relations	Owned by members	Monthly (insurance) contributions	25% of medical costs
MUGEF-CI	Côte d'Ivoire [6]1973	Judicial magistrates, civil servants, public sector and temporary staff	Members: 1990: 170,083 1991: 178,027 1992: 186,230 1993: 196,545 1994: 117,118 Dependents: 1990: 324,925 1991: 354,862 1992: 374,901 1993: 403,814 1994: 368,435	Was initiated and owned by the government at start; however, from 1989, a presidential decision to disengage the state from direct involvement has led to greater autonomy	Insurance	Drugs, dental care and prosthesis, prescription glasses and frames

Note: In this synthesis, whenever the term subscriptions is used without the qualification third party, it refers to insurance types of subscriptions or premium payments.